Claims Clues

A Publication of the AHCCCS Claims Department March, 1999

New Ambulatory Van Rates Established

The AHCCCS Administration has established urban and rural base rates for ambulatory vans, effective with claims for dates of service on and after April 1, 1999.

AHCCCS also has revised the urban and rural mileage rates for ambulatory vans. These rates also are effective April 1, 1999.

The new base rate codes and capped fees are:

- Z3621 - Ambulatory Van, Urban Base Rate, $6.00
- Z3648 - Ambulatory Van, Rural Base Rate, $6.90

The new mileage rates are:

- Z3620 - Urban Non-emergency Transport Coach Van (per mile), $1.10
- Z3643 - Rural Non-emergency Transport Coach Van (per mile), $1.27

Urban transports are those that originate within the Phoenix and Tucson metropolitan areas. ❒

Methadone Billing Limited to 3 Provider Types

AHCCCS policy allows only three provider types to bill for methadone administration.

Effective with dates of service on and after October 1, 1998, provider types 08 (MD-physician), 19 (Registered nurse practitioner), and 31 (DO-physician osteopath) may bill the AHCCCS Administration and its contracted health plans and program contractors for methadone administration.

These provider types must have category of service 47 – mental health.

Claims from other provider types will be denied.

The AHCCCS-specific codes for methadone administration are:

- W2101 - Methadone Administration (Single Dose)
- W2102 - Methadone Administration (Take Home) ❒

Providers Should Follow Claim Submission Rules

To enable the AHCCCS Claims Control Unit to process claims as efficiently as possible, providers are asked to observe several rules when submitting paper claims to the AHCCCS Administration.

Multiple-page claims that have been copied on both sides of the paper may not be submitted to AHCCCS. Each page of a claim must be on a separate piece of paper and numbered (e.g., 1 of 3, 2 of 3, 3 of 3).

Multiple-page claims should be paper clipped together in the upper left-hand corner. Providers should not staple the pages together.

If documentation accompanying the claim is too thick to clip, providers should clip the claim pages together and rubber band the documentation to the claim pages.

Providers should "burst" multiple-page HCFA 1500 claims. They should not be submitted with pages joined at the perforations. ❒

Provider File Changes Required Authorized Signature

All requests to change provider information on file at AHCCCS must be submitted to AHCCCS in writing and signed by the provider or the provider's authorized agent.

The name of the authorized signer must be on file with the AHCCCS Provider Registration Unit. Change requests submitted by someone not authorized by the provider cannot be accepted.

It is the provider's responsibility to notify Provider Registration of changes to information on file. Failure to do so may result in misdirected payments and correspondence, termination of provider status, and/or recoupment of payment. ❒

Medicare Cost Sharing Policy Finalized

The AHCCCS Office of Managed Care has finalized the Medicare Cost Sharing policy for AHCCCS contractors.

The AHCCCS state plan requires AHCCCS and its contractors to pay Medicare cost sharing for members who are dually eligible for Title XIX (Medicaid) and Medicare, subject to certain limitations. There are two types of dual eligible members: Qualified Medicare Beneficiary (QMB) dual and non-QMB dual.

AHCCCS contractors include acute care health plans, long term care program contractors, and the Arizona Department of Health Services (ADHS) regarding Title XIX behavioral health services for which ADHS is responsible.

In general, contractors are responsible for payment of Medicare coinsurance and deductibles for covered services provided to dual eligible members. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. These differences are summarized in the following table.

The Medicare Cost Sharing policy can be viewed at the AHCCCS website at www.AHCCCS.state.az.us.

Questions can be addressed to the AHCCCS Office of Managed Care. ❐

AHCCCS Contractor Cost Sharing Responsibilities
For QMB Dual and Non-QMB Dual Members

This table indicates those situations for which the contractor is responsible for Medicare cost sharing. "Yes" indicates that the Contractor has a cost-sharing obligation.

QMB Dual				
	In Network	Out of Network	Emergent Care	Medicare HMO
AHCCCS and Medicare-covered service	Yes	No	Yes	No*
Medicare-covered service, **not** covered by AHCCCS	Yes	Yes	N/A**	No*
AHCCCS-covered service, **not** covered by Medicare	Yes	No	Yes	Yes (In network)
Non-QMB Dual				
	In Network	Out of Network	Emergent Care	Medicare HMO
AHCCCS and Medicare-covered service	Yes	No	Yes	No*
Medicare-covered service, **not** covered by AHCCCS	No	No	N/A**	No
AHCCCS-covered service, **not** covered by Medicare	Yes	No	Yes	Yes (In network)

NOTES:

*Unless referred and/or authorized by the AHCCCS contractor.

**All medically necessary emergent care cost sharing is covered.

Plans Must Take Prompt Action on Clean Claims

Effective for claims received on and after October 1, 1998, AHCCCS health plans and program contractors must pay, deny, or reduce payment on 90 per cent of clean claims within 30 days of receipt unless otherwise specified in the contract with a provider.

Plans and program contractors also must pay, deny, or reduce payment on 99 per cent of clean claims within 90 days of receipt and 100 per cent of clean claims within 12 months of the date of receipt unless the contract with a provider states otherwise.

The payment requirements are in accordance with federal law and will be incorporated into the Arizona Administrative Code (R9-22-705). ❐

VFC Extended to KidsCare Recipients

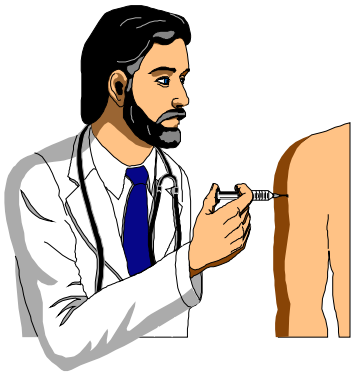
The AHCCCS Administration has entered into an agreement with the Arizona Department of Health Services (DHS) that will allow providers to administer immunizations to KidsCare recipients under the federal Vaccines for Children (VFC) program.

Under the VFC program, providers are reimbursed a capped fee for administration of vaccines to Medicaid-eligible (Title XIX) recipients 18 years old and younger. Because the vaccine is made available to providers, they must bill only for administration of the vaccine.

Under the terms of the agreement with AHCCCS, the DHS Arizona Immunization Program Office will purchase the vaccine and distribute it to providers who render services to KidsCare (Title XXI) recipients). Providers must identify KidsCare recipients on the VFC Immunization Log.

When verifying eligibility, providers can identify KidsCare (Title XXI) recipients by the following rate codes:

- 6011 - Kids <1 M&F Non-Medicare
- 6012 - Kids 1-5 M&F Non-Medicare



- 6013 - Kids 6-13 M&F Non - Medicare
- 6014 - Kids 14-19 Male Non - Medicare
- 6015 - Kids 14-19 Female Non-Medicare

When billing for immunizations provided to Medicaid and KidsCare recipients under the VFC program, providers must bill the appropriate CPT code for the immunization with the AHCCCS-specific "VA" modifier that identifies the immunization as part of the VFC program. Providers must bill only for the administration of the vaccine and not for the vaccine itself.

Providers who have questions about the program may contact the AHCCCS Office of the Medical Director at (602) 417-4410. ❒

Only Oral Surgeons May Bill E/M Codes

Only oral surgeons registered as Provider Type 07 - Dentists may use CPT Evaluation and Management (E/M) codes to bill AHCCCS for office visits.

Dentists who are not oral surgeons must use the appropriate HCPCS code ("D" code) to bill for office visits and evaluation services. The codes are:

- D0120 - Periodic oral exam
- D9430 - Office visit for observation (during regularly scheduled hours) – no other services performed
- D9440 - Office visit -- after regularly scheduled hours
- D0140 - Limited oral evaluation -- problem focused
- D0150 - Comprehensive oral evaluation
- D0160 - Detailed and extensive oral exam -- problem focused

"Coding Corner" articles in recent issues of *Claims Clues* incorrectly indicated that all dentists could bill office visits to the AHCCCS Administration using E/M codes. ❒

HCFA Warns about Requiring Cash Payments

The Health Care Financing Administration (HCFA) is warning hospitals and other providers not to attempt to require cash payments from pregnant Medicaid recipients for Medicaid-covered services.

There have been reports where anesthesiologists would not provide an epidural to a Medicaid patient in childbirth unless the woman paid in advance with her own funds.

In one reported instance, the obstetrician ordered the epidural in advance. But when the woman was in active labor, she was refused the service for lack of prepayment. Even though she tried to pay by check, credit card, and a Western Union Money Telegram, the anesthesiologist refused anything but cash.

"Treatment of a Medicaid patient in this manner is not just a concern, it is alarming," said Sally K. Richardson, director of the Center for Medicaid and State Operations.

(Continued on Page 4)

Forms Allow Providers to Fix, Check Claims

The Claims Customer Service Unit has developed two forms that enable providers to correct common claim errors and check on the status of claims.

The Claim Correction Request form allows providers to makes the following corrections without resubmitting a new claim form:

- Zero fill Medicare and TPL information
- Enter Medicare amounts if provider faxes EOMB
- Change, add, or delete a procedure modifier
- Change, add, or delete diagnosis and revenue codes (This may cause the claim to re-edit for coverage, age and gender limits, etc.)
- Change or delete procedure and NDC codes (This may cause the claim to re-edit for coverage, age and gender limits, etc.)
- Change number of units
- Change or add bill type, admit date/type/source, coinsurance days, and dates of service
- Change or add dates of service (UB-92)
- Change dates of service (HCFA 1500)
- Change or add discharge hour
- Change or add patient status
- Change, add, or delete occurrence codes and dates
- Change, add, or delete condition codes
- Change or add place of service codes

Although these changes also can be made by calling Customer Service, providers may find it more convenient to use the Claim Correction Request form.

Providers may fax the form to Claims Customer Service at (602) 253-5472.

The form must include the provider 's name, AHCCCS provider ID number, and the name of a contact person. The recipient's name and AHCCCS ID, claim date(s) of service, billed amount, Claim Reference Number (CRN), and the fields to be changed must be included for each claim. Providers also may include comments or questions.

The Claim Status Request form allows providers to check the status of claims. Status checks can be provided for paid, denied, and in-process claims.

The form must include the provider 's name, provider ID number, and the name of a contact person. The recipient's name and AHCCCS ID, claim date(s) of service, and the billed amount also must be included.

The Customer Service staff will research each claim, identify the CRN and claim status, and return the form to the provider.

Both the Claim Correction Request form and the Claim Status Request form may be obtained by calling Claims Customer Service:

(602) 417-7670 (Phoenix area)

(800) 794-6862 (In state)

(800) 523-0231 (Out of state)

Requests for the forms also can be faxed to Customer Service. ❐

HCFA Warns about Requiring Cash Payments

(Continued from Page 3)

"It is important to emphasize a hospital's responsibilities in this situation under the Medicaid program," she stated in a letter to state Medicaid directors. "A hospital which accepts a Medicaid patient for treatment accepts the responsibility for making sure that the patient receives all medically necessary services. The conditions of participation which govern hospitals providing care to Medicaid and Medicare patients require that the governing body of the hospital assures accountability of the medical staff for the quality of care provided to patients."

All providers (hospitals, physicians, etc.) who agree to treat a Medicaid patient may not require a copayment for services and must accept payment from the state's Medicaid agency as payment in full.

She said that hospitals have the responsibility of assuring the delivery of medically services. When epidurals are covered under a state's Medicaid program (They are covered by AHCCCS) and are medically necessary, "a pregnant Medicaid beneficiary is entitled to receive the service from a provider who has accepted her for a patient without the imposition of deductibles, cost sharing, or similar charges," Richardson said in her letter.

"Under federal Medicaid law, deductions, cost sharing or similar charges are not permitted for Medicaid services furnished to pregnant women," Richardson said. "Thus, a participating physician's demand for these additional payments would be in violation of the law." ❐

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

Provider type 02 (Hospital)
- Add W2101, W2102 effective 10/01/98

Provider type 08 (MD - Physician)
- Add W2101, W2102 effective 10/01/98

Provider type 09 (CNM)
- Add effective 01/01/98: 99217 – 99219, 99221, 99222, 99231, 99232, 99234, 99235, 99238, 99239, 56405, 56420, 56605, 56606, 57500, 57505, 81000 – 81007, 81025, 82948 – 82950, 90742, 92950
- If colposcopy course certificate is on file, the following codes may be billed: 57452, 57454, 57510, 57511

Provider type 10 (Podiatrist)
- Add 17000, 17002 effective 01/01/98

Provider type 11 (Psychologist)
- Add 90801, 90802, 96117 effective 10/01/97

  NOTE: Only **neuro-psychologists** may bill these codes for non-behavioral health services rendered to AHCCCS recipients.

Provider type 19 (Registered Nurse Practitioner)
- Add 90918 - 90925 effective 01/01/98

Provider type 30 (DME supplier)
- Add 99343 effective 10/01/98

Provider type 31 (DO – Physician-osteopath)
- Add W2101, W2102 effective 10/01/98

Provider type 39 (Habilitation provider)
- Add Z3643, Z3716 effective 10/01/97
- Add Z3645 effective 10/01/98

Provider type 50 (Adult foster care)
- Add Z3133 effective 09/23/98

Provider type 52 (Mental health clinic)
- Add W2101, W2102 effective 10/01/98

Provider type 64 (Detox center)
- Add W2101, W2102 effective 10/01/98

Provider type 74 (Alternative residential facility)
- Add W2101, W2102 effective 10/01/98

Provider type 77 (Mental health rehabilitation)
- Add W2101, W2102 effective 10/01/98

We're on The Web

Claims Clues is now available on the AHCCCS Web site on the Internet.

The Internet address for the AHCCCS home page is www.ahcccs.state.az.us.

To view recent issues of *Claims Clues*, select Resources, then Publications, then Guides & Manuals.

The Web site provides information about AHCCCS programs and services, including KidsCare. ❒